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Nos: 93-1408, 93-1414 and 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*

MARIO M. CUOMO, Governor of New York, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner

v.

TRAVELERS INSURANCE CO., *et al.*

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF AMICUS CURIAE OF THE SELF-INSURANCE INSTITUTE OF AMERICA, INC. IN SUPPORT OF THE RESPONDENTS

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INTEREST OF THE AMICUS

The Self-Insurance Institute of America, Inc. ("SIIA") submits this *amicus curiae* brief with the consent of Petitioners and Respondents.[1]

SIIA is a non-profit corporation composed of over 1500 members dedicated to the advancement and protection of the self-insurance industry. It is the only association in the United States which represents firms, professionals, and organizations which participate in the broad spectrum of self-insurance. Its membership includes users of self-insurance such as employers who sponsor group health plans, contract third-party administrators who process claims for self-insured health plans, stop-loss insurance companies, and other entities engaged in the self-insurance business.

SIIA's members will be significantly affected by the principal issue presented in this case—whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* preempts sections of the New York Public Health Law, § 2807-c (McKinney 1993), which require that in-patient hospital rates covered by certain payors, including ERISA regulated self-funded health plans, be increased by prescribed percentage differentials. The New York law requires commercial insurers to pay 24% more for hospital services and self-funded plans that directly reimburse hospitals to pay 13% more than Blue Cross/Blue Shield.

The issue presented is of major concern to the self-insurance industry for three reasons. First, the state law at issue clearly is designed to influence an ERISA health plan's decision as to how best to fund hospital benefits for plan participants. Thus, the state-imposed assessments will interfere with employer selection of the most effective method of providing health benefits to employees and their

[1] Original consent letters from Petitioners and Respondents have been lodged with the Court.

dependents. By increasing the cost of obtaining health services, the surcharges imposed on hospital bills directly influence the choices that employer-sponsored plans may make for health care coverage—precisely the type of impact Congress intended to avoid when it enacted ERISA.

Second, SIIA members are concerned that the state-imposed assessments will affect the structure and administration of self-funded plans, including the type and level of benefits offered by such plans. As plan costs increase, employers will be forced to adjust benefits to offset the assessments. Higher costs will result either in reduced health care benefits under such plans, or higher out-of-pocket costs for plan participants in the form of higher co-payments and deductibles, or both.

Third, the rising cost to employers of providing health benefits will escalate further if states may impose surcharges on hospitals which in turn are passed along to employer sponsored health plans, including self-funded plans. Unless the court of appeals decision which held that ERISA preempts the challenged hospital surcharges is upheld, even the continued viability of self-insurance as a cost-efficient alternative for providing health benefits to millions of employees is threatened.

Accordingly, SIIA submits this *amicus curiae* brief in support of the respondents.

SUMMARY OF ARGUMENT

In acknowledging that the New York Public Health Law is preempted by ERISA, the court of appeals recognized the expansive sweep and purpose of ERISA's preemption clause, which has been repeatedly noted by this Court. By finding that the hospital surcharge provisions have the effect of restricting the choices ERISA plans make for health care coverage, the Second Circuit properly held that such provisions are preempted because they have a clear "connection" with ERISA plans.

This finding is supportable in light of ERISA's express statutory preemption language and its legislative history which prevent state statutes from impacting on the structure, administration, and benefit design aspects of ERISA plans. Unless the Second Circuit's decision is upheld, the New York statute will cause substantial economic injury to ERISA plans and their participants by imposing on them the obligation to pay for millions of dollars in financial liabilities which are unrelated to specific benefits provided under the terms of such plans. In turn, this fiscal impact will impermissibly affect the structure and administration of ERISA plans which are critical to the sound functioning of the self-insurance system.

Failure to uphold the Second Circuit's decision will have severe detrimental implications for the continued growth of self-funded health benefit programs because the surcharges will necessarily be passed along to employers and ultimately to employees and their dependents who participate in such plans. Thus, the real losers will be employers and plan participants, including the millions of employees covered by self-insured plans who will bear the ultimate cost-shifting burden of these costs.[2] There is nothing in the statute or legislative history to suggest that Congress intended these results. In sum, the Second Circuit's reading of ERISA preemption is consistent with this Court's prior decisions and should be upheld.

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[2] Over 70 million employees and their dependents are covered by self-insured group health plans. Self-Insurance Institute of America, *TPA Client Composition Survey*, January, 1993.

ARGUMENT

I. THE SECOND CIRCUIT PROPERLY RECOGNIZED THAT ERISA PREEMPTS THE CHALLENGED STATE LAW.

A. ERISA Preemption Is Broad In Scope.

This Court has repeatedly noted the expansive sweep of ERISA's preemption clause. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). In finding the challenged surcharges preempted, the Second Circuit recognized the "unparalleled breath" attributed to ERISA's preemption clause by Congress. 29 U.S.C. § 1144(a), *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *summarily aff'd*, 477 U.S. 901 (1986). This clause states that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a) (emphasis added).

This Court has described ERISA preemption as "conspicuous for its breadth," noting that "[i]t establishes as an area of exclusive concern the subject of *every* state law that "relates to" an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 498 U.S. 52, 56-58 (1990) (emphasis added). ERISA preempts state law even if it is of *general application* and has only an indirect effect on employee benefit plans, and regardless of whether it is consistent with ERISA's substantive requirements. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Metropolitan Life*, 471 U.S. at 739-41.

"Preemption may be either express or implied," and "is compelled whether Congress' command is explicitly stated in the Statute's language or implicitly contained in its structure and purpose." *FMC Corp.*, 498 U.S. at 57. ERISA therefore preempts state law if it either (1) has

a direct or indirect "connection with" or reference to the establishment or administration [3] of self-funded ERISA plans within the meaning of § 1144(a), *FMC Corp.*, 498 U.S. at 57; or (2) conflicts with the accomplishment of the full "purpose and objectives" of Congress to make such plans "exclusively a federal concern" immune from any direct or indirect state regulation. *Shaw*, 463 U.S. at 96; *FMC Corp., supra.*

The New York law at issue is not a law of "general application" that simply regulates hospital rates in a neutral matter. The very purpose of the hospital surcharges is to influence the users of commercial insurance, self-insurance and HMOs, which are overwhelmingly employer-sponsored ERISA plans.[4] Moreover, ERISA preemption bars even a state law of general application which involves the *indirect* regulation of self-funded employee benefit plans. *Metropolitan Life*, 471 U.S. at 739.

B. The Challenged State Law Is Preempted Because It "Relates To" ERISA Plans.

ERISA preempts the challenged differentials because plainly they "relate to" ERISA plans within the "broad common-sense meaning" of having "a connection with or reference to" such plans. 29 U.S.C. § 1144(a). *Pilot Life*, 481 U.S. 41. In particular, this Court has emphasized that the preemption clause is not limited to "state laws specifically designed to affect employee benefit plans." *District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. 580, 583 (1992). *Shaw*, 463 U.S. at 98, *Pilot Life*, 481 U.S. at 48. Even though the challenged

[3] The Congressional findings and declaration of policy state that ERISA was intended to control the "establishment" as well as the "operation and administration" of employee benefit plans. 29 U.S.C. § 1001(a).

[4] In 1992, 62.5 percent of non-elderly Americans were covered by employment-based health plans. Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured*, January, 1994.

New York statute does not expressly refer to ERISA plans, under a broad reading of "relate to", the Second Circuit properly concluded that the hospital surcharges have a clear connection with such plans because they affect the choices of arangements by ERISA plans for the payment of health care benefits: [5]

> The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. *Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is suffient to constitute "connection with" ERISA plans.*
>
> Pet. App. A-22 (emphasis added).[6]

Additionally, it is well settled that a state law "relates to" an ERISA plan within the meaning of 29 U.S.C. § 1144(a) and therefore is preempted where, as here, it interferes with the freedom of employers to structure the specific benefits or other terms and conditions of their health plans. For example, in *Shaw*, 463 U.S. at 96-97, this Court held that the New York Human Rights Law, §§ 290-301 (McKinney 1982 and Supp. 1982-83), "related to" self-funded ERISA plans within the meaning of § 1144 (a) and therefore was preempted because it "prohibited employers from strructuring their employee benefit plans

[5] The purpose of the 13% surcharge is "to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers" by making the Blues—traditionally the "insurance of last resort" for high risk individuals—more competitive with commercial insurers. Appendix to the Petitioners Writ of Certiorari in No. 93-1414.

[6] References to the joint appendix filed with Petitioner's Brief are cited as "Pet. App. ——".

in a manner that discriminated on the basis of pregnancy," and required employers to pay specific benefits to employees. *See United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1160 (9th Cir. 1986) (Arizona anti-subrogation law was preempted because it prohibited employers from structuring plans to require reimbursement in the event of recovery from third party). Thus, the New York law is preempted unless it falls within the ambit of the saving clause referred to in the ERISA preemption clause.

C. The "Saving" Clause Is Not Applicable.

The Second Circuit concluded that the "saving" clause does not exempt the challenged state statutes because the hospital surcharges expressly regulate hospital rates and not any practice that constitutes the "business of insurance." ERISA's "saving" clause preserves from preemption any state law which "regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). As construed by the Court, the exemption for state regulation of insurance is a narrow one, and it applies only if the state law actually regulates the "business of insurance", and even then it applies only if the employee benefit plan is *insured* instead of self-funded. *Metropolitan Life*, 471 U.S. at 746-48. As stated in *FMC Corp.*, 498 U.S. at 64, "if the plan is uninsured, the State may not regulate." The Second Circuit applied well settled law in finding that the criteria established by the courts to determine whether a practice constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act were not met by the challenged New York statute.[7]

[7] In enacting McCarran-Ferguson, Congress declared that "the continued regulation of the *business of insurance* is in the public interest." 15 U.S.C. § 1011 *et seq.* In enacting ERISA, Congress reserved to exclusive federal authority the regulation of the field of employee benefit plans. *Shaw*, 463 U.S. at 120. In drawing upon the analysis of McCarran-Ferguson, the court of appeals properly distinguished the hospital surcharge from the "business of insurance," stating that: "[B]ecause the sucharges expressly regulate hospital rates they relate only to the contractual obligations between hospitals and insurers or insureds, but do not directly implicate the policy relationship between insurers and their insureds." Pet. App. A-29.

Moreover, the District Court properly concluded—and the court of appeals did not question—that those portions of the 13% surcharge referring to self-funded plans could not possibly fall within the scope of the "saving" clause because self-funded plans do not engage in the "business of insurance" as a matter of law.[8]

D. ERISA's "Deemer" Clause Also Bars The Challenged State Law.

The contention that the 13% surcharge is saved from preemption even in the case of self-funded plans ignores this Court's recent ruling in *FMC Corp.*, 498 U.S. at 61 (the "deemer clause" exempt[s] self-funded ERISA plans from state laws regulating insurance). The "deemer clause" limits the scope of the "saving" clause by requiring that an employee benefit plan "shall [not] be deemed to be an insurance company or other insurer . . . engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contacts." 29 U.S.C. § 1144(b)(2)(B).

In explaining the "deemer" clause's operation, this Court has held that it exempts self-funded ERISA plans from state laws that otherwise "regulate insurance" within the meaning of the "saving" clause, *FMC Corp.*, 498 U.S. at 61; *Metropolitan Life*, 471 U.S. at 724.[9]

[8] Indeed, even prior to the passage of ERISA, state courts understood that an employer who self-funds health benefits is not in the "insurance business" because the risk of loss for health benefits is retained by the employer. *Farmer v. Monsanto Co.*, 517 S.W. 2d 129 (Mo. 1974).

[9] Petitioners all but ignore the likely consequences of the hospital surcharges on self-funded plans, suggesting that since no self-

It is well settled that where, as in the deemer provision, "Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of a contrary legislative intent." *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-17 (1980). That contrary intent is not to be found in the legislative history of ERISA. Instead, ERISA and its legislative history explicitly—indeed, unqualifiedly—show that Congress knew exactly what it wanted to accomplish in 29 U.S.C. § 1144(b)(2)(B) to prevent the savings clause from leading to a characterization of employee benefit plans as insurance companies—and used unmistakably plain language to achieve that objective. Thus, any contention that ERISA does not insulate self-funded plans from state regulation not only ignores the plain language of the "deemer" clause,[10] but also the great weight of authority upon which the self-insurance industry has relied.[11]

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funded ERISA plan is among the plaintiffs in this action, questions concerning the "deemer" clause are not presented by this case. We disagree. As argued by the respondents in their brief, this case does raise important questions concerning application of the N.Y. statute to self-funded plans. SIIA, therefore, fully endorses the respondents arguments on this issue. It will not, however, repeat those arguments.

[10] Faced with a conflicting and uncertain basis for regulation among the states, the "deemer" language was utilized to create an *irrebuttable* presumption that these plans are not insurance trust companies, etc., for purposes of state regulation. The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance . . . activities generally regulated by a state. *Activity Report of the Committee on Education and Labor*, Rpt. No. 91-1785 (January 3, 1977) (emphasis added).

[11] See *Reilly v. Blue Cross and Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Standard Oil of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801

II. THE HOSPITAL SURCHARGE LAW WILL ADVERSELY AFFECT SELF-FUNDED HEALTH PLANS AND THEIR PARTICIPANTS.

A. Plan Choices of Arrangements For Providing Health Benefits Will Be Affected.

The hospital surcharges will impact on the ability of ERISA plans to select the form of health care arrangements which are most appropriate for plan participants and beneficiaries. ERISA plans have the choice of providing health coverage through: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the employer-sponsored plan is directly responsible for health care bills; (3) subscription with a health maintenance organization; and (4) a non-profit health service corporation, such as Blue Cross/Blue Shield plans. The hospital surcharges affect ERISA plans significantly and immediately—and not in a "remote and tenuous" manner—because they directly affect plan choices of the above options. The surcharges impact on the price of hospital services paid by ERISA plans (mistakenly described by petitioners as "an indirect and solely economic impact,") and are designed to make these plans less attractive than the Blues. As the Second Circuit noted, the surcharges "were designed to induce ERISA plans to switch their hospital coverage from commercial insurers to the Blues."[12] (Pet. App. A-29.) Insofar as the New York law is designed to "level the playing field" between the Blues and competing plans it has the effect

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(1981); *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1987).

[12] The New York hospital surcharges on commercial insurers, self-funded plans, and HMOs are designed to offset higher costs in Blue Cross plans with higher risk enrollees. "[E]mployers argue that such surcharges essentially make them pay twice for health care benefits—once for their own employees and a second time, through the surcharges, to subsidize uncompensated care." Geisel, *Health Care Law and Disorder*, Business Insurance, November 28, 1994 at 1.

of influencing the most fundamental choice to be made by plans—selection of the most desirable and effective method for providing and funding health benefits.

B. Health Plan Costs Will Increase Or Benefit Levels Will Be Reduced.

In enacting ERISA, Congress helped foster the favorable legal regulatory environment [13] that has resulted in the phenomenal growth of self-funded plans.[14] This growth also reflects recognition of self-insurance as a viable alternative to conventional insurance for funding health benefits, and as a cost-efficient method of providing expanded benefit coverage during a period of rapidly escalating health costs.[15]

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[13] As reflected in the congressional findings and declaration of policy, Congress drafted ERISA to carry forward public policy interests which included the following: (1) encourage the growth and development of a system of cost-effective employee benefit plans and (2) protect interstate employers and plans from inconsistent state and local regulation by providing for uniform federal law to govern employee benefits. 29 U.S.C. §§ 1001(a) and (b).

[14] According to a recent survey, 67 percent of employers of all sizes surveyed in 1992 self-fund their group health plans, up from 52% in 1989. A. Foster Higgins & Company, *Health Care Survey* (1992).

[15] Self-insurance is an important—and often-used—option for the thousands of employers who provide health benefits to their employees. Self-funding of plans provides employers flexibility to design and administer health plans to meet specific employee needs. It also provides cash flow advantages and freedom from costly state regulation. Moreover, employers who self-insure gain the financial advantage of the time-value of their capital assets. Since medical claims are paid by employers as they are submitted, firm assets can be retained by the employer. These unique characteristics and the favorable legal regulatory environment fostered by ERISA have contributed significantly to the dramatic expansion of self-insured health plans in this country in recent years. More than 50% of the U.S. workforce covered by group health plans participate in self-funded plans. HCFA Review, *Self-Insured Health Plans*, Vol. 8 No. 2 (1986).

An important factor which has contributed to this growth is the flexibility of employers within the present federal framework to design and administer self-funded plans which are as attractive as—or more attractive than—competing plans, yet which can be operated on a more cost-efficient basis. Less costly plan administration, a feature of self-funded plans, preserves plan assets which can be used to pay enhanced benefits.[16]

The surcharges will, however, result in increased hospital expenses for patients covered by employer sponsored health plans other than the Blues, thus increasing the cost of plans competing with the Blues. Requiring plans to pay hospital surcharges will result in less money in plans—which are overwhelmingly employer-sponsored ERISA plans—to pay medical benefits, thus, forcing many plans to reduce or eliminate certain benefits. For example, faced with higher costs, plans will have no choice but to restrict payments for expenses related to hospital stays or to eliminate or restrict coverage for other benefits such as vision and dental care. In other cases, in order to maintain current benefit coverages and levels, higher plan costs necessarily will be shifted to plan participants in the form of higher co-payments and larger deductibles. Thus, the hospital surcharges not only interfere with the benefit structure of ERISA plans, but also affect the financial basis upon which such plans are established and maintained.

C. The Administrative Burdens of Operating ERISA Plans Will Increase.

The New York hospital surcharge law currently affects the administration of both insured and self-insured plans. Based on plan terms and conditions, health plans cus-

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[16] In 1990, employees that self-insured health benefits reported much smaller cost increases than employers who purchased health plans from commercial insurers. Plan costs for self-funded employers rose 17.6% in 1990 to an average of $2,587 per employee from $2,200 in 1989. By contrast, costs for insured health plans jumped 22.7% in 1990 to an average of $2,608 per employee from $2,125 in 1989. A. Foster Higgins, *supra*, note 14.

tomarily provide reimbursement for "medically necessary" expenses such as the hospital stay, supplies, prescriptions, and other services. Tax assessments and fees included on hospital bills over and above the charge for covered expenses are normally treated as "excluded" items and are not reimbursable under plan terms. Since assessments such as the New York surcharges are usually included as a component of specific hospital expenses (i.e., a $250/day hospital rate would generally include a 13% surcharge which is *built into* the rate), plan administrators are required to incur substantial costs to process (i.e. to recalculate) millions of hospital rate charges submitted annually on benefit claims forms.[17] For example, these time consuming calculations—an integral component of plan administration—require costly adjustments to computer programs utilized by claims processors to handle medical claims.

Moreover, written notices and other communications with plan participants which provide an explanation of items excluded from hospital bills also affect plan administration, to say nothing of the resulting negative implications on relationships between plans and their participants. In sum, the imposed surcharges place significant administrative costs and other burdens on plans which must comply with the state statute.

Finally, another effect of allowing hospital surcharges to be imposed on ERISA plans is the increased complexity which results in administering such plans on a state-by-state basis. Since adoption of ERISA, plans have been established and operated on a nationally uniform basis and free from state regulation. If the hospital surcharges are validated, other states will be encouraged to enact laws similar to the New York statute. Some states are

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[17] Since it is customary for hospitals to require an assignment by patients to third party payors for direct reimbursement of expenses, this practice adds an additional administrative complexity to the maintenance of plans.

likely to enact such statutes, while others will choose not to do so. Monitoring and compliance with varying and often inconsistent state statutes will create significant new administrative burdens. Instead of promoting order and greater uniformity, greater fragmentation and confusion will result, particularly for large employers which operate in many states.

CONCLUSION

Inclusion of a broad preemption provision in ERISA was designed by Congress to displace state laws, primarily because of the increasingly interstate nature of employee benefit plans and the often conflicting state standards applicable to such plans. To limit the breadth of the preemption provision in connection with state hospital surcharge laws that significantly affect ERISA plans would close an important chapter in the development of ERISA's preemption policy and open a new chapter with adverse implications for employee benefit plans. In sum, failure to uphold the Second Circuit's decision will open the door for state legislatures to enact statutes which significantly affect ERISA plans in flawed reliance on a "law of general application" standard which would threaten the very viability of ERISA plans and self-insurance as an attractive alternative for providing health benefits to millions of employees and their families.

Respectfully submitted,

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